05. **Clinical Records:** All consumers for whom reimbursement is sought must have an individual clinical record. The provider shall maintain records that facilitate assessment of client need, service planning, documentation of services provided to implement the service plan, and when appropriate, discharge planning. The record must be dated, legible and meet the following requirements:

A. Contain a complete assessment of the clients gambling behavior and needs. The assessment must be in narrative form and address the following:

1. Presenting problems;

2. Social/Relationship history;

3. Educational/Vocational history;

4. Medical history;

5. Financial assessment;

6. Gambling history;

7. Tool(s) used and clinical interpretation;

8. An assessment summary;

9. Recommendations;

10. The assessment must include determination of the need for medical, substance abuse and/or mental health referral.

B. The Assessment must be completed prior to implementation of the treatment plan.

C. Each client record must contain documentation of meeting the eligibility criteria for admission found in Section 03, Consumer Eligibility.

D. The client record must document that the client received a formal orientation to the program including information concerning consumer rights and confidentiality.

E. Contain a treatment plan based upon the assessment, which is completed within the first 30 days of initiation of services, or by the fourth session, whichever occurs first. The plan must include at a minimum the following:

1. Clients strengths which can be used in addressing service needs;

2. Short and long term goals the consumer will be attempting to achieve and measurable objectives which relate to the achievement of the corresponding goals;

3. Documentation that the consumer was involved in development of the treatment goals and objectives;

4. Type and frequency of services to be received and the person primarily responsible for their provision;

5. Specific criteria for treatment completion and the anticipated timeframe;

6. Documentation of treatment plan review with the consumer a minimum of every ninety days.

F. Contain progress notes that document the type of service provided, length of service, and indicates progress in meeting the goals and objectives of the treatment plan. Progress notes must be legible, dated and signed by the person responsible for the entry. If the person making the entry has not completed all core training requirements as found in Section 01.B, there must be documentation that the progress notes are routinely reviewed by a clinical supervisor approved by the OPG.

G. The client record must document services/contacts with the client's family/affected persons. If affected persons are not

involved in the client's treatment, the reason or rationale for lack of involvement must be documented.

H. Contain a discharge summary which reflects services to the consumer upon discharge from the program. This summary must be completed within two weeks of the client's discharge date and contain:

1. A summary of services provided and the clients progress in relation to the goals and objectives of the treatment plan;

2. Recommendations, arrangements and referrals for services;